

2018-2019 Influenza Consent Form

Riley County Health Department 2030 Tecumseh Rd Manhattan, Kansas 66502 Phone: 785-776-4779

Fax: 785-565-6565 www.rileycountyks.gov/flu

DEMOGRAPHICS												
Patient's First Name: Maiden Name/Alias: Maiden Name/Alias:												
Birth Date: Age:		Age:	Phone Number:		Social Security Number:			Primary Language:				
Ethnicity: Hispanic Yes No			Asian/Pacific Islar	Caucasian or White			ctor:					
Gender Male Female			Black or African A Native American/A	Hawaiian Unknown or Other								
Mailing Address:			Apt #: City:			State:	County:		Zip Code:			
				BILLING &	HIPAA							
YesNo immunizations are covered by my health insurance? If NO: read carefully - IN ORDER TO COMPLY WITH STATE REGULATION WE ARE UNABLE TO USE (VFC) INJECTIONS UNLESS WE HAVE A WRITTEN STATEMENT FROM YOUR INSURANCE COMPANY STATING IMMUNIZATIONS ARE NOT COVERED. IF WE DO NOT HAVE A WRITTEN STATEMENT PRIOR TO INJECTION THE PATIENT WILL BE RESPONSIBLE FOR ANY PORTION THAT INSURANCE WILL NOT COVER.												
Primary Insurance Carrier Insurance Co. Name ID#: Group#												
				ib#: Pol								
Patient	's relationship to policy	holder (child,					•	_	_			
Secondary Insurance Carrier Insurance Co. Name ID#: Group#												
By my sig claims. I	Policy Holder (Name): Policy Holder's Birthdate: Patients relationship to policy holder (child, spouse, self) By my signature below, I authorize the Riley County Health Department to bill any of the medical payers as indicated above and provide necessary information to process claims. I authorize payment of medical benefits to the Riley County Health Department for services rendered and I understand I will be responsible for payment of charged deemed "uncovered" by my health insurance.											
All records of services rendered are considered confidential. This constitutes advance notice to you, the beneficiary, that if all program requirements are met by the Riley County Health Department and payment is not made by KanCare or your Health Insurance, you may be responsible for the charges. You may also be responsible for charges. If you fail to inform the Health Department of Insurance coverage in a timely manner. I have read the information above, understands the information and agree with my signature below. I also certify that the information provided on this page is true and correct to the best of my knowledge. I acknowledge that I was offered a copy of the RCHD Privacy Policy dated 9-2013.												
SIGNATURE DATE												
SIGNA	UKE							DAT	TE			
SIGNA	TURE			ATION SCREEN		TIONNAIF	RE	DAT	TE			
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